KAMALA D. HARRIS
Attorney General of California
DIANN SOKOLOFF
Supervising Deputy Attorney General
KIM M. SETTLES
Deputy Attorney General
State Bar No. 116945
1515 Clay Street, 20th Floor
P.O. Box 70550
Oakland, CA 94612-0550
Telephone: (510) 622-2138
Facsimile: (510) 622-2270
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MICHAEL DAVID HERSHBERGER** **15 Red Hill Circle, Apt. D** **Tiburon, CA 94920** **Registered Nurse License No. 521121** Respondent.	Case No. 2011-1016 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about April 15, 1996, the Board of Registered Nursing issued Registered Nurse License Number 521121 to Michael David Hershberger (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought in this Accusation and will expire on May 31, 2013, unless renewed.

//

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

6. Section 118, subdivision (b) of the Code provides that the expiration of a license does not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued, or reinstated.

STATUTORY PROVISIONS

7. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

8. Section 2762 of the Code states:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with

Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

. . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

COST RECOVERY

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

10. "Lorazepam" (trade name Ativan) is a psychotropic drug used for the management of anxiety disorders and sedation or for the short-term relief of the symptoms of anxiety. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(16) and a dangerous drug pursuant to Business and Professions Code section 4022

11. "Diazepam" (trade name "Valium") is a psychotropic drug used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(9) and a dangerous drug pursuant to Business and Professions Code section 4022.

12. "Hydromorphone" (trade name "Dilaudid) is an opiod analgesic used to relieve moderate to severe pain. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(K) and a dangerous drug pursuant to Business and Professions Code section 4022.

13. "Methadone" is a synthetic narcotic analgesic used to control moderate to severe pain. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(14) and a dangerous drug pursuant to Business and Professions Code section 4022.

14. "Morphine Sulfate" is an opiod analgesic used to control moderate to severe pain. It is a Schedule II controlled substance pursuant to health and Safety Code section 11055, subdivision (b)(1)(M) and a dangerous drug pursuant to Business and Professions Code section 4022.

15. "Pyxis" is a computerized management, storage, and medication dispensing system/machine. It is a medication cart/unit containing all medications used through a hospital. Each Pyxis is linked to the main computer maintained by the Hospital's Pharmacy Department where all Pyxis information is stored. Medical staff is given access to the Pyxis via an assigned password selected by each medical employee.

FIRST CAUSE FOR DISCIPLINE

(Grossly Incorrect and/or Grossly Inconsistent Entries in Patient Records)

16. Respondent has subjected his license to disciplinary action under section 2761, subdivision (a) on the grounds of unprofessional conduct, as defined in section 2762, subdivision (e) in that on or between December 2, 2009, and January 29, 2010, while employed as a registered nurse at John Muir Medical Center, in Concord, California, Respondent made grossly incorrect, or grossly inconsistent entries in hospital and patient records pertaining to a controlled substance and/or dangerous drug in the following respects:

A Patient A[1]

1. Patient A had a physician's order for 2.5 mg – 5 mg of Morphine every fifteen minutes as needed for severe pain. On January 24, 2010, at 2:07 a.m., Respondent withdrew from Pyxis 5 mg Morphine for patient A. Respondent documented the administration of 2.5 mg of Morphine at 2:10 a.m. and another 2.5. mg of Morphine at 3:15 a.m. At 4:37 a.m. Respondent withdrew from Pyxis 5 mg Morphine for patient A and documented the administration of 2.5 mg of Morphine at 4:40 a.m. At 5:25 a.m., Respondent withdrew from Pyxis 5 mg Morphine for patient A and documented the administration of 5 mg Morphine at 5:30 a.m., with an additional administration of 2.5 mg Morphine at 5:50 a.m. Respondent carried around the medication to be

[1] – The patient names will be released to Respondent pursuant to a request for discovery.

administered at a later time, rather than wasting the excess medication and pulling new medication for each administration.

B. Patient B

1. Patient B had a physician's order for 2.5 – 5 mg of Morphine every fifteen minutes as needed for severe pain. On January 6, 2010, at 9:41 p.m., Respondent withdrew from Pyxis 5 mg of Morphine for patient B. Respondent documented the administration of 2.5 mg Morphine at 9:47 p.m. Respondent failed to chart the administration or otherwise account for the wastage of the remaining 2.5 mg of Morphine.

2. Patient B had a physician's order for 1 mg of Ativan. On January 6, 2010, at 9:41 p.m., Respondent withdrew from Pyxis 2 mg of Ativan for patient B. Respondent documented the administration of 1 mg of Ativan at 9:50 p.m. Respondent failed to chart the administration or otherwise account for the wastage of the remaining 1 mg of Ativan.

C. Patient C

1. On January 18, 2010, at 10:00 p.m., Respondent withdrew from Pyxis 10 mg of Methadone for patient C. Patient C was a four-year-old, Rapid Medical Evaluation (RME) patient, who presented with a cough and fever. There was no physician's order for Methadone and patient C was not Respondent's patient. Moreover, the Methadone was contraindicated for patient C's condition.

D. Patient D and Patient E

1. Neither patient D nor Patient E had a physician's order for Ativan. On January 15, 2010, at 9:37 p.m., Respondent withdrew from Pyxis 2 mg Ativan for patient E. Patient E was not Respondent's patient. Respondent documented the administration of 1 mg Ativan to patient D at 9:45 p.m. Respondent failed to chart the administration or otherwise account for the wastage of the remaining 1 mg of Ativan.

2. On January 15, 2010, at 9:37 p.m., Respondent withdrew from Pyxis 5 mg of Morphine for patient E. Patient E was not Respondent's patient. There was no physician's order for Morphine for patient E. Respondent did not document the administration of Morphine to patient E or otherwise document or account for the wastage of 5 mg of Morphine.

E. Patient F

1. On January 29, 2010 at 1:45 a.m., Respondent withdrew from Pyxis 1 tablet of Vicodin for patient F. Respondent documented the administration of 1 tablet of Vicodin to patient F at 1:40 a.m. The physician's order for this patient required the administration of 2 tablets of Vicodin. Respondent charted the administration of 1 tablet of Vicodin, before the tablet was actually withdrawn from Pyxis.

F. Patient G

1. On January 27, 2010, at 7:37 p.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient G. Respondent documented the administration of 1 mg of Dilaudid to patient G at 6:00 p.m. and 1 mg of Dilaudid at 7:10 p.m. Respondent charted the administration of Dilaudid before the tablet was actually withdrawn from Pyxis. Respondent carried around the medication, to be administered at a later time, rather than wasting the excess medication and pulling new medication for each administration.

G. Patient H

1. Patient H had a physician's order for Dilaudid 1 mg IM (intramuscularly). On January 23, 2010, at 12:23 a.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient H. Respondent documented the administration of 1 mg of Dilaudid at 12:25 a.m. Respondent failed to chart or otherwise account for the administration or wastage of the remaining 1 mg of Dilaudid.

H. Patient I

1. On January 16, 2010, at 2:16 a.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient I. Respondent documented the administration of 1 mg of Dilaudid at 2:20 a.m., and 1 mg of Dilaudid at 4:00 a.m. Respondent carried around the medication, to be administered at a later time, rather than wasting the excess medication and pulling new medication for each administration.

I. Patient J

1. Patient J had a physician's order dated January 27, 2010, written at 10:42 p.m., for 2 mg of Morphine every five minutes for chest pain unresolved by Nitroglycerin. The nursing notes document the administration of meclizine and aspirin at 7:00 p.m., and the administration of

Nitroglycerin at 8:43 p.m., and again at 8:51 p.m. The physician's notes indicate that the patient's symptoms totally resolved after patient J was given aspirin, meclizine, and Nitrolglycerin .4 mg times three. The nursing notes confirm that patient J's chest pain and pressure were resolved. On January 27, 2010, at 9:41 p.m., Respondent withdrew from Pyxis 5 mg of Morphine for patient J. Respondent failed to chart the administration or otherwise document or account for the wastage of the 5 mg of Morphine.

J. Patient K

1. On January 12, 2010, at 6:33 a.m., Respondent withdrew from Pyxis 10 mg of morphine for patient K. The patient did not have a physician's order for Morphine and the patient was not assigned to Respondent. Patient K presented to the emergency room (ER) for low blood sugar and denied any pain. Respondent did not chart the administration of the 10 mg of Morphine or otherwise document or account for the wastage of the 10 mg of Morphine. The above-referenced medication was contraindicated for patient C's condition.

K. Patient L

1. On January 28, 2010, at 9:42 p.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient L. The patient did not have a physician's order for Dilaudid and the patient was not assigned to Respondent. The patient was discharged from the hospital at 10:35 p.m. Respondent failed to chart the administration or otherwise document or account for the wastage of the 2 mg of Dilaudid.

L. Patient M

1. Patient M had a physician's order for 1 mg Dilaudid IM. On January 28, 2010, at 9:53 p.m., Respondent withdrew from Pyxis 2 mg of Dilaudid for patient M. Respondent documented the administration of 1 mg of Dilaudid to patient M at 9:50 p.m. Respondent failed to chart the administration or otherwise document or account for the wastage of 1 mg of Dilaudid. Respondent charted that 1 mg of Dilaudid was administered to patient M before the medication was actually withdrawn from Pyxis.

//

//

M. Patient N

1. Patient N was admitted to the ER on January 15, 2010, and was discharged at 12:55 p.m. On January 16, 2010, at 4:14 a.m., Respondent withdrew from Pyxis 1 mg Ativan for patient N. There was no physician's order for Ativan. Respondent failed to chart the administration or otherwise document or account for the wastage of 1 mg of Ativan. Respondent withdrew medication for patient N after the patient had been discharged. On January 17, 2010, patient N returned to the ER. There was no physician's order for Ativan for patient N, and no Ativan was administered to the patient.

N. Patient O

1. Patient O had a physician's order for Ativan 1mg intra veinously (IV). On January 7, 2010, at 5:49 p.m., Respondent withdrew from Pyxis 2 mg Ativan for patient O. Respondent documented the administration of 1 mg of Ativan to patient O at 5:56 p.m. Respondent failed to chart the administration or otherwise document or account for the wastage of 1 mg of Ativan.

O. Patient Q

1. On December 18, 2009, at 11:16 a.m., Respondent withdrew from Pyxis 1 Vicodin tablet for patient Q. There was no physician's order for Vicodin. Respondent failed to chart the administration or otherwise document or account for the wastage of the Vicodin tablet.

P. Patient R

1. Patient R presented to ER for the sole purpose of obtaining copies of her test results. She did not seek treatment and was not seen by a physician or a triage nurse. On December 24, 2009, at 12:12 p.m., Respondent withdrew from Pyxis 2 mg of Morphine for patient R. Respondent failed to chart the administration or otherwise document or account for the wastage of the 2 mg of Morphine.

Q. Patient S

1. Patient S had a physician's order for Morphine 2 mg IV. On December 29, 2009, at 11:14 a.m., Respondent withdrew from Pyxis 5 mg of Morphine for patient S. Respondent documented the administration of 2 mg of Morphine to patient S at 11:20 a.m. Respondent failed

to chart the adminstration or otherwise document or account for the wastage of 3 mg of Morphine. Respondent withdrew 3 mg of Morphine in excess of the physician's order.

R. Patient T

1. Patient T had a physician's order for 2.5 – 5 mg Morphine every fifteen minutes as needed for severe pain and two physician's orders for 5 mg Morphine IM. On December 20, 2009, between 8:19 p.m. to 9:59 p.m., Respondent withdrew from Pyxis 15 mg of Morphine for patient T. Respondent charted the administration of 5 mg of Morphine to patient T at 8:10 p.m. and another 5 mg of Morphine at 9:11 p.m. Respondent charted the administration of 2.5 mg of Morphine to patient T at 9:55 p.m. Respondent charted that Morphine was administered to the patient before it was actually withdrawn from Pyxis. Respondent failed to chart the administration or otherwise document or account for the wastage of 2.5 mg of Morphine.

S. Patient U

1. Patient U had a physician's order for 1 mg of Dilaudid. On December 28, 2009, at 7:21 p.m., Respondent withdrew from Pyxis a 2 mg vial of Dilaudid for patient U. Respondent charted the administration of 1 mg of Dilaudid to patient U at 7:30 p.m. Respondent withdrew 1 mg Dilaudid in excess of the physician's order for patient U. Respondent failed to chart the administration or otherwise document or account for the wastage of 1 mg of Dilaudid.

T. Patient V

1. Patient V had a physician's order for 2 mg of Dilaudid. On December 29, 2009, at 9:49 p.m., Respondent withdrew from Pyxis 2 mg Dilaudid for patient V. The patient left the ER without being discharged. Respondent failed to chart the administration or otherwise document or account for the wastage of 2 mg of Dilaudid.

U. Patient W.

1. Patient W did not have a physician's order for Vicodin and was not Respondent's patient. On December 29, 2009, at 8:39 p.m. Respondent withdrew from Pyxis 1 Vicodin tablet for patient W. Respondent failed to chart the administration or otherwise document or account for the wastage of the Vicodin tablet.

//

V. Patient X

1. Patient X had a physician's order for Morphine 2.5 – 5 mg IV every fifteen minutes as needed for pain. On December 29, 2009, at 11:27 a.m., Respondent removed from Pyxis 5 mg of Morphine for patient X. Respondent charted the administration of 2 mg of Morphine to patient X at 11:35 a.m. Respondent failed to chart the administration or otherwise document or account for the wastage of the remaining 3 mg of Morphine.

W. Patient Y

1. Patient Y had a physician's order for Dilaudid 2 mg IV and a separate order for Valium 5 mg IV. On December 29, 2009, Respondent removed from Pyxis the following medications for patient Y: 2 mg of Dilaudid at 4:53 p.m., 10 mg of Valium at 4:54 p.m., and 2 mg of Dilaudid at 6:33 p.m. Respondent documented the administration of medication to patient Y as follows: a total of 3 mg of Dilaudid (1 mg each) was administered at 4:55 p.m., 6:10 p.m., and 6:35 p.m.; and 5 mg of Valium was administered at 4:55 p.m. Respondent failed to chart the administration or otherwise document or account for the wastage of the remaining 1 mg of Dilaudid and 5 mg of Valium.

X. Patient Z

1. Patient Z had a physician's order for Dilaudid .5 – 1 mg IV every fifteen minutes as needed for severe pain. On December 28, 2009, Respondent removed from Pyxis the following medications for patient Z: 2 mg of Dilaudid at 9:12 p.m., and 2 mg of Ativan at 9:38 p.m. Respondent represented (but did not chart) that he administered 1 mg of Dilaudid to patient Z at 8:03 p.m. Respondent wasted 1 mg of Ativan with a witness. Patient Z did not have a physician order for Ativan and Respondent failed to chart the administration or otherwise document or account for the wastage of the remaining 1 mg of Ativan. Respondent represented that he administered 1 mg of Dilaudid to patient Z prior to the time the Dilaudid was withdrawn from Pyxis and did not chart the administration of the Dilaudid. Respondent failed to chart the administration or otherwise document or account for the wastage of the remaining 1 mg of Dilaudid.

//

Y. Patient AA

1. Patient AA had a physician's order for Morphine 2.5 – 5 mg IV every fifteen minutes as needed for severe pain. On December 20, 2009, at 5:26 p.m., Respondent removed from Pyxis 5 mg Morphine Sulfate for patient AA. Respondent charted the administration of 2.5 mg of Morphine to patient AA at 5:30 p.m. Respondent failed to chart the administration or otherwise document or account for the wastage of the remaining 2.5 mg of Morphine.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Gross Negligence)

17. Respondent has subjected his license to disciplinary action under section 2761, subdivision (a)(1) on the grounds of gross negligence based on the acts and/or omissions set forth in paragraph 16, above.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Incompetence)

18. Respondent has subjected his license to disciplinary action under section 2761, subdivision (a)(1) on the grounds of incompetence based on the acts and/or omissions set forth in paragraph 16, above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters alleged in this Accusation, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 521121, issued to Michael David Hershberger;

2. Ordering Michael David Hershberger to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

//

//

//

//

3. Taking such other and further action as deemed necessary and proper.

DATED: June 29, 2011

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SF2011900252
90189205.doc